

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G121		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/14/2011	
NAME OF PROVIDER OR SUPPLIER PASSAGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 125 NORTH 200 EAST COLUMBIA CITY, IN46725			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: September 13 and 14, 2011.</p> <p>Facility number: 000658 Provider number: 15G121 AIM number: 100234300</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/21/11 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			
W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to ensure the direct care staff were following the Reporting Incidents of Abuse, Neglect, Exploitation, Etc. policy as indicated in 1 of 24 Bureau of Developmental Disabilities Services (BDDS) reports for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p>			W0149	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice</p> <p>A full investigation of the allegation of verbal abuse toward client #1 was completed. The allegation of abuse was substantiated, and the employee was terminated.</p> <p>How will we identify other residents having the potential to be affected by the same deficient</p>		10/02/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Facility records were reviewed on 9/13/11 at 1:59 P.M. including the BDDS reports between the dates of 11/10/10 and 9/13/11. The BDDS reports indicated the following:</p> <p>- a BDDS report dated 8/12/11 for an incident on 8/11/11 at 7:15 A.M. indicated "On 8/11/11 [client #1] reported to the Qualified Developmental Disabilities Professional (QDDP) that he had a situation in the group home this morning that upset him. [Client #1] said he got up early to take a shower in the morning since he was going to be out with his mother in the afternoon, when it was his assigned shower time. A staff member [staff #10] 'got in my face and was yelling at me and being disrespectful to me.' An investigation was started. On 8/11/11 at 10:30 P.M. a third shift (staff #5) called the group home manager to report he had witnessed the incident from the morning of 8/11/11 between [client #1] and [staff #10]. He reported (staff #10) had been verbally abusive to [client #1]. He had observed [staff #10] standing within an inch of [client #1's] face yelling at [client #1] for about 2 minutes. He (staff #5) further reported that she (staff #10) then sent him (client #1) to his room to calm down for over an hour. [Staff #10] was suspended from duty beginning 8/12/11</p>				<p>practice: Staff training regarding Passages policy to prohibit abuse, neglect, and mistreatment was provided to all staff working in this home. Whati measures will be puti intio place or whati systemic changes will be made tio ensure tihati tih deficienti practices do noti recur Staff training regarding Passages policy to prohibit abuse, neglect, and mistreatment is provided upon hire and annually thereafter How will tih corrective actions be monitioered tio ensure tih deficienti practice will noti recur QDDP will ensure training is provided regarding Passages abuse, neglect, and mistreatment policy upon hire and annually thereafter by reviewing training documentaton annually and when new employees are hired. QDDP will ensure all allegatons oft abuse, neglect, and mistreatment is reported immediately to the appropriate enttes . Whati is tih datie by which tih systemic changes will be completied 10/2/11</p>		

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	<p>pending the outcome of the investigation."</p> <p>- a BDDS follow-up report dated 8/16/11 indicated the following: "Staff was not suspended immediately when [client #1] made his report due to the uncertainty of whether [client #1] was exaggerating or falsifying the truth...The staff that reported the incident was counseled on 8/18/11 on the importance of reporting incidents immediately."</p> <p>- a BDDS follow-up report dated 8/16/11 indicated the following: "On 8/11/11 [staff #10] worked two shifts 6:45 A.M.-8:15 A.M. (when the incident occurred) and 2:45 P.M.-10:30 P.M.. Staff #10 also worked 6:45 A.M. - 8:15 A.M. on 8/12/11." The allegation of abuse was substantiated, and staff #10 was terminated on 8/15/11.</p> <p>The facility Reporting Incidents of Abuse, Neglect, Exploitation, Etc. policy dated 3/11, was reviewed on 9/14/11 at 9:20 A.M.. The policy indicated the following: " It is the policy of [Name of facility] that abuse/neglect of clients served will not be tolerated, and that all reports of abuse/neglect or other incidents involving persons served be reported to the proper authorities to ensure the protection of human rights....Any staff who suspects an individual is the victim of abuse or</p>						

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	<p>neglect shall report it...Any staff suspected of abuse, neglect or exploitation will be suspended until the case is fully investigated [name of facility] will remove the staff person from direct contact with consumers...."</p> <p>An interview was conducted with the QDDP on 9/14/11 at 1:40 P.M.. When asked if staff had followed the agency policy the QDDP stated, "No." The QDDP indicated they had completed an investigation and the allegation was found to be substantiated. The QDDP indicated staff #10 had continued to work in the home after client #1 had made the allegation. The QDDP indicated staff #5 had not immediately reported the incident of abuse between client #1 and staff #10.</p> <p>1.1-3-2(a)</p>						
W0153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of</p>			W0153	<p>Whati corrective action(s) will be accomplished fior tihese residents</p>		10/02/2011

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	<p>staff abuse involving 1 of 4 sampled clients (client #1) was immediately reported to the administrator and the Bureau of Developmental Disabilities Services (BDDS) reports as evidenced in 1 of 24 BDDS reports reviewed, in accordance with state law.</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/13/11 at 1:59 P.M. including the BDDS reports between the dates of 11/10/10 and 9/13/11. The BDDS reports indicated the following:</p> <p>- a BDDS report dated 8/12/11 for an incident on 8/11/11 at 7:15 A.M. indicated "On 8/11/11 [client #1] reported to the Qualified Developmental Disabilities Professional (QDDP) that he had a situation in the group home this morning that upset him. [Client #1] said he got up early to take a shower in the morning since he was going to be out with his mother in the afternoon, when it was his assigned shower time. A staff member [staff #10] 'got in my face and was yelling at me and being disrespectful to me.' An investigation was started. On 8/11/11 at 10:30 P.M. a third shift (staff #5) called the group home manager to report he had witnessed the incident from the morning of 8/11/11 between [client #1] and [staff</p>		<p>found tio have been affected by tihe deficienti practice</p> <p>Staft who observed incident oft abuse was retrained on Passages policy oft reportng incidents oft abuse, neglect, mistreatment immediately.</p> <p>How will we identify otihers residentis having tihe potential tio be affected by tihe same deficienti practice:</p> <p>All staft was provided training on Passages policy oft reportng incidents oft abuse neglect, mistreatment immediately.</p> <p>Whati measures will be puti into place or whati systemic changes will be made tio ensure tihati tihe deficienti practices do noti recur</p> <p>All allegatons oft abuse, neglect, and mistreatment will be reported to the appropriate enttes immediately per agency policy.</p> <p>How will tihe corrective actions be monitioed tio ensure tihe deficienti practice will noti recur</p> <p>QDDP will ensure all allegatons oft abuse, neglect, and mistreatment is reported immediately per Passages policy.</p> <p>QDDP will ensure staft receives training upon hire and annually thereafter on Passages policy oft reportng incidents oft abuse, neglect, and mistreatment immediately.</p> <p>Whati is tihe datie by which tihe systemic changes will be completed</p> <p>10/2/11</p>		

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	<p>#10]. He reported (staff #10) had been verbally abusive to [client #1]. He had observed [staff #10] standing within an inch of [client #1's] face yelling at [client #1] for about 2 minutes. He (staff #5) further reported that she (staff #10) then sent him (client #1) to his room to calm down for over an hour. [Staff #10] was suspended from duty beginning 8/12/11 pending the outcome of the investigation."</p> <p>- a BDDS follow-up report dated 8/16/11 indicated the following: "Staff was not suspended immediately when [client #1] made his report due to the uncertainty of whether [client #1] was exaggerating or falsifying the truth...The staff that reported the incident was counseled on 8/18/11 on the importance of reporting incidents immediately."</p> <p>An interview was conducted with the QDDP on 9/14/11 at 1:40 P.M.. The QDDP indicated they had completed an investigation and the allegation was found to be substantiated. The QDDP indicated staff #5 had not immediately reported the incident of abuse between client #1 and staff #10.</p> <p>1.1-3-2(a)</p>						

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W0155	<p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p>Based on record review and interview, the facility failed to immediately suspend a staff to ensure the possibility of further potential abuse after 1 of 4 sampled clients (client #1) made an allegation of staff abuse.</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/13/11 at 1:59 P.M. including the BDDS reports between the dates of 11/10/10 and 9/13/11. The BDDS reports indicated the following:</p> <p>- a BDDS report dated 8/12/11 for an incident on 8/11/11 at 7:15 A.M. indicated "On 8/11/11 [client #1] reported to the Qualified Developmental Disabilities Professional (QDDP) that he had a situation in the group home this morning that upset him. [Client #1] said he got up early to take a shower in the morning since he was going to be out with his mother in the afternoon, when it was his assigned shower time. A staff member [staff #10] 'got in my face and was yelling</p>			W0155	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice</p> <p>Employees who are alleged to have engaged in abuse, neglect, or mistreatment will be suspended immediately pending the outcome of a thorough investigation.</p> <p>How will we identify others residents having the potential to be affected by the same deficient practice:</p> <p>Employees who are alleged to have engaged in abuse, neglect, or mistreatment will be suspended immediately pending the outcome of a thorough investigation.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practices do not recur</p> <p>Staff training regarding Passages policy regarding abuse, neglect, and mistreatment will be provided upon hire and annually thereafter.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur</p> <p>QDDP will ensure all policies related to abuse, neglect, and mistreatment is being followed</p>		10/02/2011

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